Commonwealth of Massachusetts

Board of Registration In Medicine

Annual Report
~ 2002 ~

2002 Board Members

Martin Crane, MD

Peter N. Madras, MD

Mary Anna Sullivan, MD

Roscoe Trimmier Jr., Esq.

Randy Wertheimer, MD

Honorable E. George Daher

Rafik Attia, MD

Asha Wallace, MD

Dorothy Keville, M.Ed

The Board of Registration in Medicine consists of seven members who are appointed by the Governor to three-year terms. There are two public members and five physician members of the Board. Each member also serves on one or more Committees of the Board. The Board members are volunteers who give tirelessly of their time and talent to lead the work of the agency.

The following Board members completed their terms during 2002:

Peter Madras, MD
The Board Chair from 2002-2002, Dr. Madras also served as chair of the Complaint Committee. He is credited with revitalizing the agency through his leadership in securing increased funding.

Dr. Rafik Attia, MD
Completing his second two-term appointment, Dr. Attia has brought stability and institutional memory to the Board during a period of great change. He has been a leader in bringing the need for medical error prevention programs to the forefront in Massachusetts.

Mary Anna Sullivan, MD
Dr. Sullivan chaired the Patient Care Assessment Committee in 2002. She represented the Board on the MA Coalition for the Prevention of Medical Error and is a well-respected expert in the field. She also acted as Board liaison to the Physician Health & Compliance program where her experience as a psychiatrist greatly strengthened the Board's efforts to work with impaired physicians.

Dorothy Keville, M.Ed.
Ms. Keville, a public member of the Board, was a tireless voice for the rights of patients. She also led Board efforts to revise the Board's regulations. Ms. Keville served on both the Complaint and Licensing Committees.

Board of Registration in Medicine
2002 Annual Report

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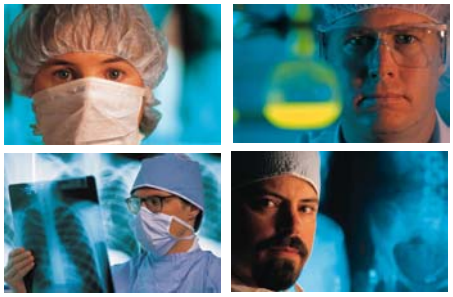


STRUCTURE OF THE BOARD OF REGISTRATION IN MEDICINE

The Board of Registration in Medicine consists of seven members who are appointed by the Governor to three-year terms. A member may serve only two consecutive terms. Members sometimes serve beyond the end of their terms before a replacement is appointed. There are two public members and five physician members of the Board. Each member also serves on one or more Committees of the Board. Committees of the Board include:

Complaint Committee

Members review allegations against physicians and recommend cases for disciplinary action to the full Board. The Complaint Committee members oversee the "triage" process by which complaints are prioritized, direct the Litigation staff in setting guidelines for possible consent orders, recommend matters for prosecution to the full Board, and hold intensive remedial and investigatory conferences with physicians who are the subject of complaints.

Data Repository Committee

Members review reports filed about physicians from statutorily mandated reporting sources. Reports include malpractice payments, hospital discipline reports, and reports filed by other health care providers. Although sometimes similar in content to allegations filed by patients, Data Repository reports are subject to different legal standards regarding confidentiality and disclosure than are patient complaints. The Data Repository Committee refers cases to the Enforcement Unit for further investigation, as needed.

Licensing Committee

Members review applications for licensure and requests for waivers from certain Board provisions. The members present candidates for licensure to the full Board. The two primary categories of licensure are full licensure and limited licensure. Limited licensees include all physicians in training, such as those enrolled in residency programs.

Patient Care Assessment Committee

Members work with hospitals and other institutions to improve quality assurance programs through the review of Major Incident Reports. These reports describe adverse outcomes, full medical reviews of the incidents, and the corrective action plans of the facilities. The plans are part of the Committee's commitment to preventing patient harm through the strengthening of medical quality assurance programs in all institutions. The work of the Committee has become a national model for the analysis of systems to enhance health care quality.

Committee on Acupuncture

The Board of Registration in Medicine also oversees the licensing and discipline of acupuncturists through the Committee on Acupuncture. The current members of the Committee on Acupuncture include four licensed acupuncturists, one public member, and a designee of the Board Chair.

Dr. Rafik Attia
Board Secretary

Functions and Divisions of the Agency

The Executive Director of the agency reports to the Board and is responsible for hiring and supervising a staff of legal and medical professionals who perform research and make recommendations to the members of the Board on issues of licensure, discipline, and policy. In addition, the Executive Director is responsible for all management functions, budget and contract issues, and public information activities of the agency. The Executive Director represents the Board on national and international issues and organizations.

Although the policies and practices of the Board of Registration in Medicine are established by its Board, the agency resided administratively within the Office of Consumer Affairs and Business Regulation (OCABR) until December 31, 2002. As of January 1, 2003, the agency resides within the Department of Public Health, but with the same level of autonomy as it has always been afforded by the legislature. The Executive Director oversees senior staff members who, in turn, manage the various areas of the agency.

The Divisions of the agency include the following:

Licensing Division

The Licensing staff performs the initial review of all applications for medical licensure to ensure that only competent and fully trained physicians are licensed in Massachusetts. The staff also works with applicants to provide requirements for examinations and training that must be met before a license will be issued.

Enforcement Division

The Enforcement Division is responsible for the investigation of all consumer complaints and all statutory reports referred from the Data Repository Committee. The Consumer Protection Unit coordinates the initial review of all complaints as part of its "triage" process. Complaints with allegations of substandard care are reviewed by experienced clinical nurses from the Clinical Care Unit, and then sent to outside expert reviewers. The Disciplinary Unit is staffed by prosecutors who represent the public interest before the Complaint Committee, the Board, and the Division of Administrative Law Appeals (DALA). Experienced investigators research complaints by interviewing witnesses, gathering evidence, and working with local, state, and federal law enforcement agencies.

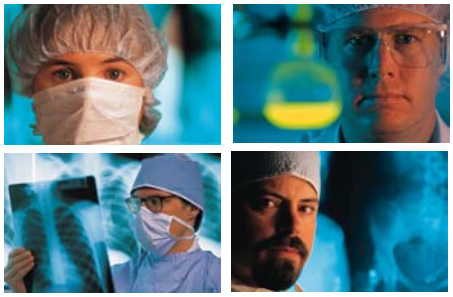
Education & Outreach Division

Massachusetts continues to lead the nation in the quality and accessibility of information for patients and the general public. Since the launch of the Physician Profiles project in 1996, thousands of Massachusetts residents have found the information they needed to make informed health care decisions for their families using this innovative program.

In addition to on-line access to Profiles, the Board of Registration in Medicine assists consumers who do not have Internet access through a fully staffed Call Center. Call Center employees answer questions about Board policies, assist consumers with obtaining complaint forms or other documents, and provide copies of requested Profiles documents to consumers.

Division of Law & Policy

The Division of Law & Policy operates under the supervision of the General Counsel. The Office acts as legal counsel to the Board during adjudicatory matters and advises the Board and staff on relevant statutes and regulations. Among the areas within the Division of Law and Policy are the Office of the General Counsel, the Patient Care Assessment Unit, the Data Repository Unit, the Physician Health & Compliance Unit, and the Committee on Acupuncture.



Executive Director's Report - *Nancy Achin Audesse*

2002 was a year of great challenge and growth for the Massachusetts Board of Registration in Medicine. The faltering economy put tremendous strain on the state budget. The Board had been severely under-funded for many years; additional cuts related to the state's fiscal crisis would have devastated the agency and threatened to undermine two years of progress in all areas of operations. In response, the Board sought new funding opportunities that would not depend upon additional appropriations from the state budget.

After careful analysis, it was determined that the licensing fees in effect were inconsistent with national averages. These fees had not been increased in nearly twenty years. One obstacle to achieving appropriate funding through revision to the licensing fee structure was a high level of resentment within the profession related to the fee retention structure in place under the existing laws. Historically, the agency retained only 40% of fees paid by licensees and 60% was retained by the state's general fund. There was concern that any increase in fees would be used to offset deficits in other state accounts. To resolve this concern, the Board worked with the Legislature to rewrite the fee retention language in the governing statute. Through a statutory change that allowed the Board to keep 100% of the increased fees, improved funding was achieved without requesting additional appropriations from the state's depleted General Fund. The Board and Staff of the agency wish to acknowledge the many people and institutions whose efforts made this initiative successful. In particular, the leadership of Senator Richard Moore was instrumental in bringing all parties together on this vital issue.

The Board of Registration in Medicine continues to develop meaningful technological enhancements to better reach its goals. In addition to the early development of plans for on-line license applications, the agency is in the process of finalizing a major systems innovation. During 2002, the agency undertook a project to capture all licensing, disciplinary, and other files into an electronic document imaging and management system. This project will help the agency to achieve long-term cost savings through increased efficiency and to respond more quickly to public records requests.

During the past three years, the agency has made tremendous improvement in the management of its caseload of consumer complaints. When the new management team assumed responsibility for the agency, the case

management statistics were daunting: there were nearly seven hundred open cases and the average case was over two years old. Many cases were so old that they no longer met the requirements of the Board's "staleness policy" for consideration. Certainly, the situation did not represent the high level of customer service that citizens expect and deserve from their government.

Today, the complaint process is managed in a far more responsive manner. Both the open caseload and the average age of cases have been cut in half.

Caseload Statistics

YEAR	Average Age of Complaint	Open Complaints at End of Year
2002	**235.3 days**	**358**
2001	356.78 days	361
2000	456.29 days	537
1999	790.51 days	698

Along with the success of the Enforcement Division in 2002, the Board experienced the highest level of usage of its public information services in its history. The Physician Profiles program continues to meet the needs of patients. Originally designed with consumers in mind, the service is now widely used by the media, health care facilities, researchers, and medical services employment agencies. There were over 13 million "hits" into the Physician Profiles website in 2002. Another 24,256 Profiles were mailed to consumers without Internet access who requested assistance from the Board's Call Center.

Looking Forward

The accomplishments of the past year have been impressive, but the Board of Registration in Medicine will not rest on its laurels. Instead, the Board has identified barriers to continued improvement and has developed strategies to respond to these challenges. In 2003, the Board will build upon its successes of the past year.

Among the specific goals for 2003 are the following projects and initiatives:

Continued Focus on Technology

The Board of Registration in Medicine is a nationally recognized leader in the use of technology to assist consumers and physicians. The Board will complete an aggressive document imaging and electronic document management project in 2003. The completion of the project will allow the Board to share more information with consumers and physicians through its website and other points of access. The Board is

also fully committed to the implementation of on-line licensure for physicians. An on-line licensure system will help Massachusetts to continue to attract the best physicians from around the world. By reducing its internal administrative tasks through such a system, the Board can refocus more resources on reviewing, investigating, and verifying the credentials of applicants.

The Board also recognizes its responsibility to use technology to reduce the cost of health care whenever possible. In 2003, the Board will expand a model program designed to help hospitals and health plans maintain important information about their affiliated physicians. The Board will supply regular updates of license status, disciplinary actions, and other information to hospitals and insurers. These entities will help the Board to keep accurate and timely information on hospital affiliations, insurance affiliations, and other information of interest to the consumers who access the Board's "Physician Profiles" system each day. Through collaboration, creativity, and leadership the Board hopes to improve the quality of physician information available to both the profession and consumers.

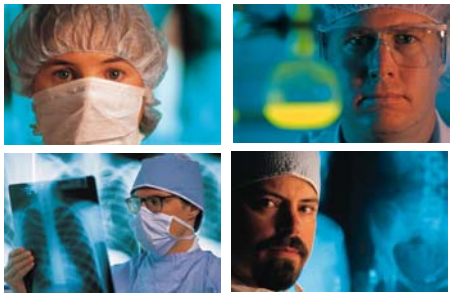
Clinical Skill Assessment

The Board of Registration in Medicine hopes to develop and test a pilot program to provide clinical skill assessment and retraining opportunities in Massachusetts. Currently, the only comprehensive program for such testing is in Colorado. The cost of the program itself is high – the added burden of travel costs makes the program unduly expensive for Massachusetts physicians. A Clinical Skills Program would provide assurances that physicians wishing to return to practice after a hiatus have maintained their skills and knowledge; assist the Board, hospitals, and health plans in determining the level of clinical competence of physicians about whom there are concerns; and offer clinical training opportunities to instruct physicians in the use of new technology, implementation of "best practice" protocols, and other vital aspects of health care quality assurance.

The program would be funded primarily through fees assessed to the participants. Other costs would be covered by private entities. Similar to its relationship with the Physician Health Services program for impaired physicians, the Board of Registration in Medicine would maintain regulatory oversight in cases involving potential harm to patients, but much of the program would be privately run.

Patient Protection Initiatives

The Massachusetts Board of Registration in Medicine continues to provide leadership in many areas of patients rights and consumer protection. The agency is using its unique position as a repository for all data related to medical malpractice payments, physician licensure, and patient complaints to bring balanced and complete data to policy makers. Through its acclaimed Patient Care Assessment Program, the Board is able to enhance patient safety and quality assurance efforts throughout Massachusetts.



Enforcement Division Report– *Barbara A. Piselli, Director*

The **Enforcement Division** of the Board is mandated by statute to investigate all potential disciplinary matters involving physicians and acupuncturists licensed to practice medicine within the Commonwealth of Massachusetts. The Division strives to pursue complaints against licensees efficiently, fairly and effectively in order to ensure that the public is protected and that Board statutes, regulations and policies are followed.

Throughout 2002, the Division continued to meet its mandate of public protection through ongoing changes and goals that focused on decreasing the backlog of open cases, improving communication with consumers filing complaints against physicians, expediting the review and resolution of cases and increasing disciplinary actions. The Enforcement Staff's commitment in these areas had a major and positive impact on the successful functioning of the Enforcement Division during 2002. The case backlog has been drastically reduced, cases are reviewed and resolved more effectively and disciplinary actions are on the rise.

The Enforcement Division is supervised by the Director of Enforcement and is comprised of three units: the **Consumer Protection Unit**, the **Clinical Care Unit** and the **Disciplinary Unit**. Each Unit plays an essential and important role in the Enforcement Division's mission to ensure quality health care for consumers.

Consumer Protection Unit

The **Consumer Protection Unit** (CPU) is the first line of review for consumers filing complaints with the Board. It is staffed by the Unit Manager and two administrative staff members. Staff screens the complaints, flags serious and priority cases to bring to the attention of the Director of Enforcement for immediate action, obtains responses from physicians and coordinates the initial review of all complaints as part of its "triage" process.

The consumer protection staff coordinates the Triage Team and other patient advocacy initiatives. The Unit also keeps consumers updated on the status of their complaints during the initial intake and screening phase. During 2002, the Unit docketed 677 cases. The Consumer Protection Unit received an additional 227 communications from consumers that were not docketed. Often, these communications involve complaints

against non-physician health care professionals. The Consumer Protection Unit staff assists these consumers in identifying the appropriate regulatory agencies to assist them.

Clinical Care Unit

The **Clinical Care Unit** (CCU) reviews complaints alleging substandard care. The Unit is staffed by the Unit Manager and two nurse reviewers, all experienced clinicians, as well as a paralegal. Staff members analyze patient records and physician responses, act as liaisons with Board experts, coordinate remedial conferences, assist the Division's attorneys with the preparation and litigation of complex substandard care cases and prepare various analyses for the Data Repository Committee and the Licensing Committee.

Roscoe Trimmier, Jr., Esq.
Complaint Committee Chair
Public Member

Disciplinary Unit

The **Disciplinary Unit** is responsible for the investigation and litigation of all cases that may result in disciplinary action against licensed physicians and acupuncturists. The Unit is staffed by a Managing Attorney, six complaint counsels (or Board prosecutors), four investigators, a paralegal and an administrative assistant. Complaints are referred to the Unit by the Data Repository Committee, the Consumer Protection Unit, and various other sources. Staff members interview witnesses, gather evidence, work with local, state, and federal law enforcement agencies on coordinated investigations, and present cases to the Complaint Committee and the Board. The Complaint Counsels also draft pleadings, negotiate Consent Orders, identify and present cases for Summary Suspension and prepare and litigate Board cases at administrative hearings at the Division of Administrative Law Appeals (DALA).

Enforcement Division Accomplishments During 2002

Increased Disciplinary Actions And Prioritization Of Cases

During 2002, the Board investigated and finalized nearly 700 cases of the 948 cases brought before the Complaint Committee. Each case requires prompt, but thorough, investigation of the allegations, a complete review of a physician's response, and analysis of other materials that are germane to the case. In 2002, 73 cases ended with final disciplinary actions imposed by the Board. Sixty-eight (68) different physicians were involved in the 73 disciplinary actions.

These disciplinary action figures represent a 24% increase compared to 2001 results, a 55% increase from 2000, and a 79% increase from the 1999 results. Final disciplinary actions are the result of intensive investigations, victim and witness interviews, expert review, and medical record analysis that can be

presented to the Complaint Committee, an independent Magistrate at DALA, and, ultimately, the Board. A single complex case involving allegations of substandard care can require hundreds of hours of input from expert witnesses, Board clinical review staff, and Board prosecutors. 2002 was the most productive year in Board history in nearly every aspect of performance for the Enforcement Division.

Types of Disciplinary Action

If the Board determines that disciplinary action is appropriate, the matter may be resolved through a negotiated settlement such as a Consent Order. Beginning in 2002, Enforcement staff decreased the negotiation period from 60 to 30 days, resulting in the more expeditious resolution of these matters. During 2002, 37 physicians entered into Consent Orders. These actions are public and disciplinary in nature.

If a negotiated settlement is not a realistic alternative, the Board issues a Statement of Allegations and refers the matter to DALA for a full evidentiary hearing on the merits. There were 22 cases pending at DALA as of December 31, 2002. These 22 cases are comprised of 39 separate complaints. Although no longer within the administrative purview of the Board, the cases remain in the Board's open case backlog until a recommended decision is received from the DALA magistrate and the Board issues a Final Decision & Order. Twenty-one (21) cases (20 physicians and one acupuncturist) were referred to DALA during 2002. There were seven full evidentiary hearings at DALA during 2002. Once the evidentiary hearing has been completed, the DALA Administrative Magistrate issues a recommended decision to the Board containing findings of facts and conclusions of law. The Board considers the recommended decision, as well as the parties' dispositional arguments, and then issues a final decision and order.

Disciplinary Actions and Related Activity

Category	2002	2001	2000	1999
Doctors Disciplined	**68**	55	44	38
Statements of Allegations Issued	**57**	39	40	29
Summary Suspensions	**5**	7	7	5
Voluntary Agreements Not to Practice	**10**	4	5	5
TOTAL ACTIVITY	**140**	105	96	77
% Increase from Prior Year	**+33.3%**	+9.4%	+24.6%	N/A

Prioritization Of Cases

When a doctor appears to be a serious threat to the public health, safety, or welfare, it is the responsibility of the Complaint Counsel to bring this matter to the attention of the Board to recommend that the doctor no longer practice medicine until safeguards are in place. In the most serious cases, the Complaint Counsel may recommend that the Board summarily suspend the license of a physician or attempt to seek a voluntary agreement not to practice medicine from the physician. These actions are immediate, public and disciplinary. Of greatest importance, these actions ensure that the licensee cannot continue to practice medicine while the Board order remains in effect.

Dr. Randy Wertheimer
Complaint Committee
Physician Member

The team approach is being utilized on a more widespread basis, especially on complicated or emergency cases. Paralegals, investigators, nurse investigators and supervisors play a more integral role in the investigation and prosecution of each case. Another Complaint Counsel is assigned to "second-seat" the primary attorney on complex adjudicatory matters.

The most serious cases are given the highest priority in terms of resource allocation, investigation and prosecution. The investigative team makes these cases their top priority, acting immediately to fully and fairly investigate the allegations before making a recommendation to the Board. Cases with disciplinary potential are identified and prioritized sooner due to changes in the triage process.

The Executive Director and the Director of Enforcement have conducted statewide proactive outreach with law enforcement agencies to familiarize these organizations with the mission of the Board and encourage prompt reporting of criminal misconduct by physicians. These efforts are resulting in cooperative and collaborative investigative efforts by law enforcement agencies and the Board.

Case Management And Expedited Case Review And Resolution

The Enforcement Division made tremendous efforts to maintain an appropriate caseload of open investigations. These efforts have resulted in the significant reduction of all backlog matters as well as the expedited review, investigation and resolution of incoming matters.

The intake, review and tracking of complaints continue to improve. Licensees are immediately requested to respond to complaints so that all relevant information concerning a complaint can be reviewed by the Triage Team in a timely manner. This has resulted in the more expedient review and resolution of cases that do not merit formal disciplinary actions by the Board. Again in 2002, 90% of these cases were resolved within 60 days of receipt, compared to 180 days during 2000 and 365 days or longer prior to 2000.

Docketed Complaints Opened, Closed, and Pending

COMPLAINTS	2002	2001	2000	1999
Docketed	**677**	670	626	584
Closed	**680**	865	773	365
Pending as of 12/31	**358**	361	537	698

Investigators, Nurse Investigators and Complaint Counsels have regular case review meetings with their supervisors. This process assists in the identification of priority cases, problem areas and the need for additional resources as well as the implementation of appropriate timelines.

Enhanced Communications With Complainants

The Consumer Protection Unit now sends the physician's response to complainants in every case. In the past, this was only done at the specific request of the complainant. Complainants are also sent letters informing them of the resolution of their complaints with specific details on the Board action taken. Complainants are provided with an opportunity to submit an impact statement to the Board during the sanctioning phase of adjudicatory matters.

Cases Alleging Substandard Care

The Clinical Care Unit received 101 new complaints alleging substandard care this year. Approximately 60% of these cases are on the disciplinary track and are joint investigations with Complaint Counsels. This is an increase of 25% over last year's substandard care cases on the disciplinary track.

Number of Complaints Alleging Substandard Care

Status	2002	2001	2000
Opened	**101**	111	177
Closed	**90**	168	322
Pending	**110**	99	156

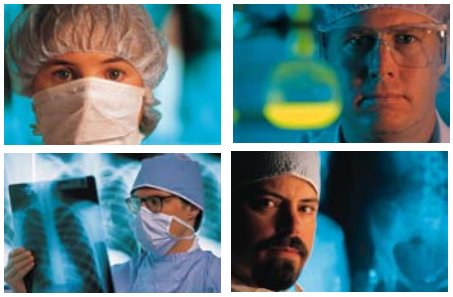
The Board continues to utilize the services of the Center for Health Care Dispute Resolution/Maximus (CHDR) and outsourced the expert review of many of these cases. CHDR is a peer review organization based in New York that provides expert medical opinions by board-certified physicians. Outsourcing of these cases has significantly reduced the backlog of open substandard care cases, resulting in the prompt review and evaluation of substandard care matters and allowing the CCU staff to work more closely on potential disciplinary matters.

Other Complaint Committee Actions

The Complaint Committee and the Enforcement Division have worked expediently and efficiently to review all cases in a timely manner. Once an investigation is completed, it is the responsibility of staff members to present the case to the Complaint Committee, a subcommittee of the Board consisting of at least two members. The Complaint Committee makes a determination as to whether disciplinary action should be taken against physicians and makes recommendations accordingly to the full Board. The Complaint Committee also reviews and resolves all matters without disciplinary potential, often with informal Board action such as letters and remedial conferences.

Sexual Misconduct Investigations During 2002

Special safeguards implemented during 2000 remain in place for sexual misconduct cases. All complaints that allege sexual misconduct, including inappropriate touching or remarks, are immediately docketed and given to the Director of Enforcement for assignment to an Investigator and Complaint Counsel. All such allegations are prioritized and fully investigated. The alleged victim is interviewed in person whenever possible, as is the physician. Serious cases of sexual misconduct are always evaluated immediately in order to determine if a summary suspension of the physician's license would be appropriate.



PUBLIC INFORMATION DIVISION REPORT – *Claudette Houle, Director*

The Board of Registration in Medicine continues to provide important health care information to thousands of consumers, physicians, and health care organizations. The impact of the Board's first-in-the nation Physician Profiles program, initiated in 1996, is generating interest beyond the borders of Massachusetts. Since its inception, the Board has continued to receive requests for information from state legislatures and medical boards across the country. The Profiles program has generated international interest as well. Japan, in particular, through its media, has contacted the Board on six separate occasions to interview, film, and learn more about the program and the Board's approach to disciplinary actions in order to further educate its own citizenry.

From January through December 2002, BORIM has tracked more than 13 million page hits on its website--a substantial amount of activity. In tracking these numbers, the Board has learned that Internet users in countries such as Canada, Germany, the United Kingdom, Israel, Singapore, Saudi Arabia, Brazil, New Zealand, Mexico, Finland, France, Italy, Mexico and Spain, have logged on to the Board's website on a regular basis. This extraordinary interest is one of the many results of the Board's comprehensive education and outreach efforts, which have made the Board's work even more visible.

The Board also operates a Public Information Unit for consumers who do not have Internet access or who may need additional services. In 2000, the Public Information Unit handled 14,868 calls from consumers. In 2002, over 30,000 calls were received. In addition, 24,256 Profiles were processed and mailed to consumers.

The Public Information Unit staff also performs most data entry relating to the updates in the Physician Profiles system. The Public Information Division has experienced a significant increase in the number of updates from 2000 to 2002. In 2000, there were eight thousand updates. In 2002, there were more than twelve thousand updates – more than a 50% increase. The increased usage is a direct result of physicians and consumers taking advantage of a much broader scope of information available on the agency's website. Physicians can now download license application kits for full and/or limited licenses and use the website to verify approval of their licenses. The agency's website includes Board educational bulletins and linkage to other sites as a supplement. Consumers and physicians may also access information on board policies,

prescribing guidelines, and review banner headlines for information on various topics by logging on to the website at www.massmedboard.org. They can also activate "consumer services" to learn how to file a complaint, download the complaint form, or locate answers to frequently asked questions before filing a complaint. The Board also provides a list of disciplinary actions taken against a physician.

E. George Daher
Chief Justice, MA Housing Court

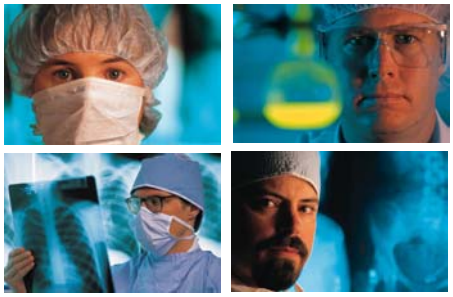
As part of its ongoing commitment to increase communications with health care professionals and patients, the Board of Registration in Medicine has also established a Speakers Bureau. Speaking to local groups affords the Board an opportunity to inform citizens and the medical community on licensing, disciplinary, and other health care issues. To better serve the growing Latino community in Massachusetts, the Board now offers an English-to-Spanish version of instructions and complaint forms that can be downloaded from the website.

On June 26, 2002, NBC Nightly News highlighted the public information services provided by the Massachusetts Board of Registration in Medicine by showing an example of the Profiles page during its newscast. It informed viewers that Massachusetts is the only state that posts complete records of physicians going back 10 years. During the same piece, Charles Inlander, head of the People's Medical Society, a consumer watchdog group, stated that "it would probably take you days to find information about just one doctor that would be equivalent to what's in the Massachusetts information."

Physician Profiles Output Summary

Year	Calls Received	Profiles Mailed/Faxed	Physician Profiles Website Hits	Total # Profiles *
1996	17,127	25,771	0	25,771
1997	43,698	57,619	529,250	586,869
1998	30,085	32,316	1,642,500	1,674,816
1999	22,642	22,779	2,555,000	2,577,779
2000	20,400	15,647	2,573,439	2,589,086
2001	35,876	32,490	3,705,668	3,738,158
2002	**30,102**	**24,256**	**13,397,881**	**13,422,137**

(Web Hits+ Call Center Requests Processed)



LICENSING DIVISION REPORT – *Rose Foss, Director*

The Licensing Division is the point of entry for physicians applying for a license to practice medicine in the Commonwealth and has an important role in protecting the public as the "gatekeepers" of medical licensure. The Division conducts an in-depth investigation of a physician's credentials before forwarding a license application to the Board for issuance of a license to practice medicine.

There are three types of licenses: full license, limited license, and temporary license. A full license allows a physician to practice medicine independently. A limited license is issued to a physician who is participating in an approved residency or fellowship program in a teaching hospital under supervision. Massachusetts teaching hospitals have earned their reputations as the most respected training programs in the world. The Licensing Committee and staff work closely with all Massachusetts teaching hospitals to facilitate the licensure of their trainees. The Board also issues temporary licenses to eminent physicians who previously held a faculty appointment in another country or territory, and who are granted a faculty appointment at a medical school in the Commonwealth. Temporary licenses are also granted to physicians for providing *locum tenens* services or for participating in a continuing medical education program in the Commonwealth. Full licenses are renewed every two years on the physician's birth date, and limited licenses are renewed at the end of each academic year.

Dr. Martin Crane
Licensing Committee Chair

Before an application for a full, limited or temporary license is forwarded to the Board for approval, the Licensing Division conducts an extensive investigation of the applicant's credentials. The Licensing Division collects documentation from primary sources that include verification of medical school training, licensing examination scores, postgraduate training, evidence of professional experience and profiles from the Federation of State Medical Boards, National Practitioner Databank, and the American Medical Association. In addition to processing license

applications, the Licensing Division also provides information and verification of the status of a physician's license for state licensing boards, credentialing for privileges at healthcare facilities and consumers.

Licensing Division Statistics

License Status Activity	2002	2001*	2000	1999 *
Initial Full Licenses	1,709	1,705	1,642	1,670
Full Renewals *	7,286	20,960	6,331	21,141
Lapsed Licenses	123	136	137	175
Initial Limited Licenses	1,418	1,419	1,384	1,509
Limited Renewals	2,513	2,663	2,591	3,246
Temporary (initial) Licenses	17	9	6	10
Temporary Renewals	16	5	7	7
Voluntary Non-renewals	427	494	320	527
Revoked by Operation of Law	611	784	474	803
Deceased	131	93	7	123
TOTAL	**14,251**	**28,268**	**12,899**	**29,111**

** The majority of full licenses are renewed in odd-numbered years, 1999, 2001, etc.*

Licensing Committee Activity Report

The Licensing Committee is a subcommittee of the Board comprised of two Board members. The primary role of the Licensing Committee is to ensure that every physician applying for licensure in the Commonwealth is qualified and in compliance with the Board's licensing regulations.

As a subcommittee of the Board, the Licensing Committee is responsible for reviewing all license applications with legal, medical, malpractice or competency issues. The Licensing Committee reviews physicians applying for an initial limited license, or renewing a limited license, who had competency issues or substandard clinical performance in a training program. The Licensing Committee customarily interviews the physician and the program chairperson in such cases before making a recommendation on issuance of a

limited license to the full Board. The Committee may recommend approval or denial of a limited license, depending on the whether the Committee is satisfied that the physician will be closely supervised in the training program. A recommendation for issuance of the limited license in such cases is usually contingent on an agreement with the physician and the program chairperson to provide regular monthly, bi-monthly or quarterly performance monitoring reports to the Board. Renewal of the limited license is contingent on satisfactory performance monitoring reports over the course of the entire academic year. Performance monitoring agreements are customarily required for the duration of the training program. However, the performance monitoring may be discontinued if the physician has a track record of satisfactory clinical performance. If the Licensing Committee determines that there is a pattern of substandard clinical performance anytime during the academic year, the Committee may recommend additional action.

Licensing Committee Activity Report

Cases Reviewed by Licensing Committee	2002	2001	2000	1999
Malpractice	**35**	23	29	19
Competency Issues	**90**	78	93	51
Legal Issues	**27**	39	24	28
Medical Issues	**32**	28	28	26
CME Waivers	**0**	12	5	3
Miscellaneous Issues	**110**	134	88	141
Total Cases Reviewed	**294**	**314**	**267**	**268**

Performance Monitoring Agreements

Since implementation of the performance monitoring program in 1997, there had been a steady decrease in the number of limited licenses issued with performance monitoring agreements. However, there was a two-fold increase in the number of performance monitoring agreements in 2002, as compared with 2001. It remains to be seen if this increase is a statistical oddity or the beginning of a trend of larger numbers of licensure applicant with problematic histories.

Dr. Asha Wallace
Licensing Committee

2002 Licensing Division Accomplishments

Scanning License Files

Approval of funding by the Legislature for the purchase of scanning equipment has enabled the Board to scan over 77,000 full renewal applications dated from 1999 to 2002; over 80,000 full license applications dating back to 1985; and over 3,500 limited license applications. The Licensing Division performed the initial testing and implementation of this system for the entire agency. Over two million pages of documents were scanned, indexed, and audited in Licensing.

Scanning licensing documents has provided instant access, retrieval and secure electronic storage of information. Retrieval of information can now be accomplished in seconds by a click of a mouse. A workflow has been developed for automated routing of all license documents, and inbound documents and license applications are scanned within 24 hours. Immediate retrieval of current and archived license applications and documents is vital to the Board's Enforcement and Legal investigation process.

Limited License Workshops

In 2002, the Licensing Division conducted three Limited License Workshops (at Beth Israel Deaconess Medical Center, St. Vincent's Hospital and Lahey Clinic) for training program coordinators/administrators, who are responsible for ensuring that residents and fellows who staff the Commonwealth's training programs are licensed in accordance with the Board's regulations. The annual Limited License Workshops are crucial in providing information on changes in the limited license process, new forms and new procedures. The workshops also provide an opportunity for the exchange of information between Board staff and the training program coordinators to identify opportunities for improving the limited license process. In addition to the Limited License Workshops, Board staff and the Coalition of Teaching Hospitals (COBETH), which is comprised of representatives from the major teaching institutions, meet annually to discuss issues of mutual concern, exchange ideas and work collaboratively to improve the limited license process.

Initial Full License Application Process Revised

Revision of the full license process, to allow applicants to collect specific documents in sealed envelopes and submit them with the full license application, has expedited the process and significantly reduced the processing time for an average full license with no malpractice or legal issues from an estimated 56 days to 35 days. The revised license process has also significantly reduced the volume of incoming mail, since the majority of the required documents are received with the license application. Additionally, there has been a substantial reduction in staff time required to sort, identify and file license documents. Verification of medical school training, license examination scores, Education Commission for Foreign Medical Graduates

(ECFMG) status reports, legal reports, malpractice information and medical issues cannot be collected by the applicant. They are sent directly to the Board from the primary source. Both the Federation of State Medical Boards, who provide verification of license examination scores, and the ECFMG, who provide status reports for international medical graduates, are developing software for electronic verifications that will further expedite the licensing process.

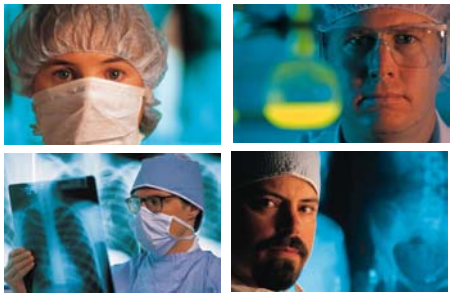
License Division Survey

As an ongoing initiative to improve customer services, the Licensing Division randomly surveys newly licensed physicians to identify opportunities for improvement and to expedite the process within the scope of the Board's regulations. Survey responses are tabulated using the Likert Scale from 1–5, with 1 rated as "poor," 2–3 rated as "average," and 4-5 in the "excellent" range. The overall average score in 2002 was 4.23, which is in the high average to excellent range.

Survey Questions	**2002 Responses** (n=97)	**2001 Responses** (n=80)
1. Was the Licensing staff courteous?	4.20	4.15
2. Was the staff knowledgeable?	4.28	3.93
3. Did the staff provide you with the correct information?	4.23	4.00
4. Did the staff direct you to the appropriate person to answer your questions?	4.20	4.06
Overall average score	**4.23**	**4.03**

On-Line License Renewal

The Board is participating in the development of an on-line license renewal project with the MassELicense initiative to provide Internet access for license renewal. With on-line access to the Board's database, a physician will be able renew a license and update demographic information and continuing medical education credits between renewal cycles.



DIVISION OF LAW AND POLICY REPORT – *Pamela J. Wood, General Counsel*

The **Division of Law and Policy** is responsible for overseeing compliance with the broad array of the Board of Registration in Medicine's legal obligations, ranging from statutory reporting to adherence to Commonwealth policies and practices. The Division is also responsible for managing the Board's adjudicatory matters, from consent orders through statements of allegations, final decisions and orders, and appeals.

The Division is made up of four units: the **Office of the General Counsel**, the **Patient Care Assessment Unit**, **the Data Repository**, and the **Physician Health and Compliance Unit**. The Board's **Committee on Acupuncture** is also located in the Division of Law and Policy.

Office Of The General Counsel

The Office of the General Counsel (OGC) advises the Board on a full range of issues such as disposition of adjudicatory matters, ethics considerations, interpretation of laws and regulations, and formulation of policy. The OGC also reviews and drafts regulations and proposed legislation, and is responsible in the first instance for reviewing and advising on all legal issues affecting the agency.

Significant Legal Decisions

There were several legal decisions of note in 2002 in Board-related matters. On September 9, 2002, a Single Justice of the Supreme Judicial Court issued a decision affirming the Board's final order *In the Matter of Randolph Ramirez, M.D.,* Adjudicatory Case No. 01-08-DALA. In its decision, No. SJ-02-0200, the Court upheld the Board's indefinite suspension of a physician's license, pursuant to Board regulation providing for discipline based upon a physician "having been disciplined in another jurisdiction in any way by the proper licensing authority for reasons substantially the same as those set forth in M.G.L. c.112, §5 or 243 CMR 1.03(5)." This significant decision affirmed the Board's authority to discipline solely on the basis of out-of-state discipline, without having to relitigate the underlying facts that led to that original discipline.

On October 29, 2002, a Justice of the Superior Court issued a decision dismissing a suit filed against a physician who provided expert testimony in a Board case. The suit was filed by the respondent physician

against whom the expert testified. The basis for the court's dismissal was M.G.L. c.231, §59H (the "anti-slapp" statute). See *Kennard Kobrin, M.D. vs. David Gastfriend, M.D.*, C.A. No. 2002-00362. This was an important decision for the Board, since it underscored the protections available to physicians who may hesitate to assist the Board by serving as experts, for fear of litigious retaliation by the physician under investigation.

Records Retention and Paperless Systems

The Legal Division coordinated a major revision of the Board's Records Retention Schedule to facilitate the agency's transition from a paper-based system to optical media. The Division forged important alliances with the State Archives and the Supervisor of Public Records, which resulted in the agency agreeing to serve as the model for all of state government on scanning and electronic records retention.

The Board now has a Records Retention Schedule that allows it to seek permission from the Records Conservation Board to archive or destroy any document that has been confirmed to have been accurately scanned into the Board's imaging system. Ultimately, this will result in significant savings in storage space while improving workload efficiencies through desktop access to all Board records.

Administrative Transition

Pursuant to legislative amendment, the Board of Registration in Medicine has relocated administratively to the Department of Public Health (DPH) from the Office of Consumer Affairs and Business Regulation (OCABR), effective January 1, 2003. The General Counsel met with DPH and OCABR to examine potential statutory, regulatory, and other issues raised by the relocation, and assisted in the preparation of a report to the legislature on these topics. Because the Board of Registration in Medicine remains autonomous by statute (M.G.L. c.112, § 1), the transition has not had a major impact on the day-to-day work of the agency, and the Board anticipates that the transition to DPH will be a productive one.[1]

Additional OGC Activities

The OGC worked with the Board and legislative leaders on a variety of statutory and regulatory issues, including revisions to the Board's regulations, potential legislative enhancements to personal privacy of physicians, and statutory amendments to clarify the Board's responsibilities and authority.

The General Counsel represented the Board at a conference sponsored by the National Committee on Quality Assurance in Washington, DC to examine the possibility of developing nationwide standards for physician information websites, similar to the Board's Physician Profiles. As the sole state medical board represented at the conference, the Massachusetts board was recognized as the "gold standard" on Physician Profiles.

[1] Seven other health boards, formerly within the Division of Professional Licensure, have also relocated to DPH. Unlike the Board of Registration in Medicine, however, these health Boards report to and are supervised by DPH.

Oversight of Adjudicatory Matters

The Legal Division maintains the Board's active adjudicatory case files, prepares its Final Decisions and Orders, and tracks its disciplinary numbers. In 2002, the Board initiated a total of 73 disciplinary actions against 68 physicians (five of whom were disciplined more than once). The Board issued 12 Final Decisions and Orders and entered into 37 Consent Orders. The Board also issued 57 Statements of Allegations and referred 20 cases to DALA. As of December 31, 2002, there were 22 cases pending at DALA and seven matters on appeal to the courts.

ADJUDICATORY FIGURES CY 2002

Total Number of Disciplinary Actions Taken*:*		**73**
a.	Consent Orders:	37
b.	Final Decision and Orders:	12
c.	Summary Suspensions:	5
d.	Final Decision and Orders On Summary Suspensions:	(1) [2]
e.	Resignations:	8
f.	Voluntary Agreements:	10[3]
g.	Assurance of Discontinuance:	0
h.	Department of Revenue Suspension Orders	1

Discipline by Type of Sanction[4]:		
a.	Admonishment:	0
b.	Censure:	2
c.	Continuing Medical Education Requirement:	8
d.	Community Service:	1
e.	Costs:	0
f.	Educational Service:	0
g.	Fines:	13
h.	Monitoring:	0
i.	Practice Restrictions:	10
j.	Probation:	13
k.	Reprimand:	16
l.	Resignation – part a:	3
m.	Resignation – part b:	5
n.	Revocation:	7
o.	Summary Suspension – part a:	4
p.	Summary Suspension – part b:	1
q.	Suspension:	12
r.	Stayed Suspension:	11

[2] This decision is not counted in this calendar year because the original suspension occurred and was counted in the last calendar year.
[3] This number includes both Agreements Not to Practice and Agreements for Practice Restrictions.
[4] The Board may impose more than one form of discipline in an individual case, such as a fine and CMEs.

Data Repository

The Data Repository Counsel receives and processes statutory reports concerning physicians licensed in the Commonwealth. Data Repository staff work with the Board's Data Repository Committee to review mandated reports to determine which cases or matters should be referred to the Board's Enforcement Division, and to develop policies relating to statutory reporting. The Data Repository Unit (DRU) also disseminates information regarding Board disciplinary actions to national data collection systems and via the Board's website, and ensures that appropriate statutory report information is accurately posted on Physician Profiles.

In 2002, the Data Repository received and processed 2,765 statutory reports. One hundred and fourteen (114) reports were forwarded directly to the Enforcement Division for further investigation. Twenty-seven (27) statutory reports related to potential impairment issues were forwarded directly to the Physician Health and Compliance Unit.

Statutorily Mandated Reports Received

STATUTORY REPORTS RECEIVED	2002	2001	2000	1999
Renewal "yes" answers - malpractice	**809**	3612	751	2842
Renewal "yes" answers- other	**57**	206	64	328
Court Reports - malpractice	**780**	654	758	846
Court Reports – criminal	**5**	0	0	1
Closed Claim Reports	**811**	1096	1021	988
Initial Disciplinary Action Reports	**106**	114	124	66
Subsequent Disciplinary Action Reports	**117**	124	103	27
Professional Society Disciplinary Action Reports	**1**	0	0	0
5D (government agency) Reports	**38**	21	26	32
5F (peer) Reports	**37**	8	18	26
ProMutual Remedial Action Reports	**3**	3	0	0
Self Reports (not renewal)	**1**	0	3	5
TOTALS	**2,765**	5,838	2,868	5,161

Note: Physicians renew bi-annually. 2002 was not a renewal year.

Mandated Peer Reports

In 2002, 37 Mandated Peer (known as 5F) Reports were submitted to the Board, representing a significant increase over the number of 5F reports received in the past. The increase in the number of 5F reports may be due to Board efforts to educate health care providers about their reporting obligations. Both Board and staff members have made presentations to physicians throughout the Commonwealth at Grand Rounds and other physician education opportunities to address this issue.

Health care facilities submitted 106 Initial Disciplinary Action Reports, a slight decrease from 114 reports filed in 2001. These reports reflect disciplinary actions taken by the facilities in respect to the privileges of affiliated physicians.

There were 38 Government Agency (5D) Reports submitted, an increase from 21 reports filed in 2001. The majority of these reports are Department of Public Health reports of investigations of "adverse events" that occurred at health care facilities. During 2002, the Board of Registration in Medicine worked with representatives of the Department of Public Health to standardize the reporting of events involving physicians to the Board.

Finally, insurers submitted 811 Closed Claim Reports in 2002, a decrease from the 1,096 Closed Claims Reports submitted in 2001. These reports must be submitted whenever an insurer makes a malpractice payment on behalf of a physician.

Direct Referral of Statutory Reports

In accordance with the Board's Data Repository Committee (DRC) policy, the Data Repository Counsel reviews statutory reports and determines whether certain reports should be referred to the Board's Enforcement Division or Physician Health and Compliance Unit.

In 2002, 114 reports were referred directly to the Enforcement Division for investigation, based on DRC policy (open complaint, out-of-state discipline or allegations that raise the possibility of summary suspension). Twenty-seven (27) reports (renewal "yes" answers on Questions 23 and 24 concerning physical or mental health impairments, and/or DUI charges) were referred directly to the Physician Health and Compliance Unit.

Statutory Reports Reviewed by the Data Repository Committee

Statutory reports not referred directly to the Board's Enforcement Division or Physician Health and Compliance Unit are reviewed by DRU staff for presentation to the DRC. When required, DRU staff investigates the reports and presents them to the DRC with a recommendation for action. This investigation

process includes obtaining responses from physicians and evaluations from health care facilities, as well as other information necessary for the DRC to determine whether further action is required. In 2002, the DRU staff presented 114 cases to the DRC. The DRC took the following actions:

* 46 cases - Closed with no action.
* 21 cases - Referred to Enforcement Division.
* 4 cases - Referred to Physician Health and Compliance Unit.
* 4 cases - Remedial Conference recommended.
* 25 cases - Closed with letter of advice, concern or warning.
* 14 cases - Deferred disposition of matter until further information obtained.

In addition, the DRC referred two of the above matters that raised quality assurance issues to the Board's Patient Care Assessment Unit.

Reports to Outside Entities

During 2002, Data Repository Counsel reported all formal Board actions to the Federation of State Medical Boards, National Practitioners Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), as required. (All formal Board actions are reported to the Federation of State Medical Boards. With the exception of Probation Modifications, all formal Board actions are also reported to the NPDB and/or HIPDB.)

Physician Profiles

During 2002, Data Repository Counsel was responsible for assuring the accuracy of the malpractice payment, hospital discipline and criminal conviction information published on the Physician Profiles. The Data Repository Counsel reviewed and resolved approximately 20 complaints by physicians about the information published on their Physician Profiles. Two Profile disputes were presented to the DRC for disposition.

Education and Enforcement of Mandated Reporting Obligations

Data Repository Counsel interprets and enforces the mandated reporting requirements for Board members, staff and mandated reporters (including physicians and other health care providers, health care facilities, medical malpractice insurers, and civil and criminal courts). DRU staff assists mandated reporters with the technical aspects of filing mandated reports.

Physician Health And Compliance

The Physician Health and Compliance Unit (PHC) advises the Board on issues related to chemical dependency and mental or physical impairment that may affect a physician's ability to practice medicine safely and competently. Board Counsel for Physician Health and Compliance works closely with the Massachusetts Medical Society's Physician Health Services (PHS) to provide oversight of impaired physicians, to ensure compliance of physicians in PHS contracts, and to receive and respond to reports of non-compliance with contracts. In addition, PHC assists in educational outreach programs throughout the Commonwealth.

Dr. Mary Anna Sullivan
Board Liaison
Physician Health Programs

PHC Case Presentations

The PHC Unit prepares and presents cases before the Board, the Complaint Committee, and the Licensing Committee, serving as the agency's primary resource on matters related to physician health. In 2002, the PHC Unit presented 79 cases to the Board, which represented approximately 40% of the cases heard by the Board over the course of the year. The PHC Unit also presented 45 matters to the Complaint Committee for its review.

The PHC staff also worked closely with the Licensing Unit and reviewed the licensing files of applicants who disclosed problems with disruptive behavior, substance abuse, mental health and criminal matters. Fifty-five (55) matters were presented to the Licensing Committee, the majority involving limited license applicants who were scheduled to begin residency programs in July.

Physician Oversight

The PHC Unit conducted 33 physician interviews in 2002. Most of these physicians were interviewed after reports of non-compliance with PHS contracts, such as positive drug tests. Physicians were also interviewed after disclosing information on renewal applications, such as a criminal charge of Operating Under the Influence of Alcohol or a medical leave of absence to address an episode of major depression. Physician Health Services made 42 reports regarding PHS-monitored physicians. These reports included 22 positive drug tests, 6 reports of contractual non-compliance and 5 missed tests.

Patient Care Assessment

The Board's Patient Care Assessment (PCA) Committee and Unit are responsible for implementing regulations that require most health care facilities in the state to establish and maintain institutional systems of quality assurance, risk management, peer review and credentialing, known collectively as PCA programs. Over 800 health care facilities in the state are affected by the PCA requirements, including hospitals, clinics, HMOs, and nursing homes.

Dr. Peter Madras
Outgoing Board Chair
PCA Committee Member

The Legislature placed responsibility for institutional systems of quality assurance at the Board in 1986. It is a function unique among the nation's medical licensing boards; its presence at the Board of Medicine recognizes the principle that without physician leadership and participation, institutional quality assurance programs cannot and will not be successful. An approved PCA program is a condition of hospital licensure. Moreover, no licensed physician in Massachusetts may work at a health care facility that does not have an approved PCA program. The Legislature also mandated, by statute, that information submitted to the Board as required by the PCA regulations is confidential and not subject to subpoena, discovery or introduction into evidence.

PCA Plans and Reports

The Board ensures that health care facilities have PCA programs in place by reviewing and approving their PCA plans. To monitor the on-going operations of a facility's PCA program, the Board requires three types of reports, two of which are, in essence, quality assurance "progress" reports and must be submitted to the Board on a routine basis.

The third type of report, called the "major incident" report, is the principal method by which the Board ensures that institutional quality assurance systems are functioning effectively and appropriately. Major incidents are serious, unexpected patient outcomes, which may result from medical error or from unanticipated, unpreventable events. The Board has received 263 major incident reports thus far relative to events that occurred in 2002 (facilities have approximately three months following an incident to submit a report, so additional 2002 reports are continuing to arrive at the Board).

Hospital Meetings

As part of its review of major incidents, the PCA Committee and staff work closely with the reporting facility. If the PCA Committee is not satisfied with the facility's response to an event, it often recommends corrective action to the facility. If the PCA Committee remains dissatisfied, it calls for a meeting with the facility's administrative and medical leaders. In 2002, the PCA Committee and staff held three such meetings.

PCA Updates

By their reviews of major incident reports, the PCA Committee and staff are in a unique position to identify quality assurance problems in health care that require broad, state-wide attention. When such problems are identified, advisories known as PCA Updates are distributed to all hospitals in the state. The Updates alert the facilities about the issue, describe the problem and, sometimes with the aid of advice from experts, offer possible solutions.

In 2002, the PCA Committee and staff distributed one such advisory, "Deep Vein Thrombosis and Pulmonary Embolism with Knee Injuries," in response to several major incident reports of patients who developed pulmonary emboli, some of which resulted in death or anoxic brain damage. The Update urged all physicians caring for patients with knee injuries to consider the use of prophylactic anticoagulation for prevention, if the benefits of this therapy outweigh the risks, or venous ultrasound for early diagnosis and possible treatment. The Update also emphasized the importance of focused medical histories and physical exams to identify those patients with knee injuries who are at increased risk for venous complications.

List of PCA Updates

* Oncology Drug Administration (2/93)
* Intravenous Potassium Chloride (1/97)
* Pediatric Neurosurgical Procedures (1/98)
* Adrenocortical Insufficiency Secondary to Previous Treatment with Adrenal Corticosteroids (10/98)
* Laparoscopic Injuries (5/99)
* Radiology Coverage in Emergency Rooms (6/00)
* Unread Electrocardiograms (8/00)
* Serious Neurologic Complications in Patients Receiving Neuraxial Anesthesia/Analgesia When Taking Medications that Alter Clotting Mechanisms (8/01)
* Unexpected Deaths of Patients Receiving Patient-Controlled Analgesia (11/01)
* Deep Vein Thrombosis and Pulmonary Embolism with Knee Injuries (1/02)

Committee On Acupuncture

Committee on Acupuncture

John G. Myerson, Ph.D., Lic.Ac. *Chairman*

Weidong Lu, Lic.Ac.
Vice Chairman

Wen Juan Chen, Lic.Ac.
Secretary

Nancy Lipman, Lic.Ac.
Member

Amy Soisson, Esq.
Public Member

The Committee on Acupuncture works in cooperation with the Board of Registration in Medicine to regulate the practice of acupuncture. The Committee on Acupuncture functions include setting standards for acupuncture licensure and practice through 243 CMR 4.00 and 243 CMR 5.00 (the acupuncture regulations), approving acupuncture schools and training programs, reviewing applications for licensure, setting standards for safe practice, disciplining acupuncturists who engage in misconduct, and interpretation of the regulations and/or discussion on any relevant issues. The Committee on Acupuncture meetings, which are open to the public, are held every three months at the Board of Registration in Medicine. The Acupuncture Unit aids the Committee in its work; in addition to providing assistance to the Committee members, the Unit handles issues relating to acupuncture raised by the public and licensees, and works with the Legal and Disciplinary Units within the Board on matters involving acupuncture.

In 2002, the Committee on Acupuncture granted 87 full licenses and took action on seven disciplinary matters.

Committee On Acupuncture Actions On Disciplinary Matters

Summary Suspension	1
Resignation	1
Dismissed with Letter of Warning	3
Dismissed with Letter of Concern	1
Dismissed	1